MeCMS ADJUSTMENT FUNCTIONALITY

As you know, MECMS has not had the capability to adjust claims that have been submitted and/or paid incorrectly. Over the past several months, an upgrade to the MeCMS system has been designed, developed and tested for this purpose. This is a very significant opportunity to resolve outstanding claims issues.

Because of the potential volume of claims requiring adjustments, this process needs to be managed in a careful manner to avoid problems for providers and to prevent processing volume issues for MeCMS. As was true for the void initiative, please note that the adjustment functionality will not address all MeCMS claims payment issues. Examples of issues that will not be resolved with the adjustment functionality include certain limit problems and, for hospitals, paper claims submitted for co-insurance and deductibles after Medicare. For this reason, there are some claims that **should NOT** be adjusted when the adjustment functionality is implemented. The general rule of thumb is that if *current* claims are processing accurately, similar past claims can be adjusted correctly.

Voids versus Adjustments: To assist you in determining whether a claim should be voided or adjusted, the following guidance is provided.

- Adjustments may be requested for claims paid in error when. . .
  - Charges billed need to be corrected
  - The number of days or units billed is incorrect
  - The cost of care/assessment was figured incorrectly
  - Procedure Codes and/or Revenue Codes (except Room & Board codes) are incorrect
  - Changes have occurred in the Third Party Liability (TPL) payment. (You must send an Explanation of Benefits.)

  Please note: Except in certain cases, such as correcting a coding issue, an adjusted claim increases or decreases the original dollar amounts.

- Voids must be requested for claims that were billed. . .
  - With an incorrect procedure code and/or revenue code for room and board
  - With wrong recipient ID number
  - With the wrong provider ID number
  - Or if bill was for services not rendered

  Please note: A voided claim refunds the entire amount and reverses the original claim.

Implementation: It is very important that your business office personnel follow the instructions for using the adjustment functionality carefully and that they work closely with MaineCare personnel in the process. As you begin to submit adjustments to MeCMS, you should test the system's ability to process your adjusted claims by submitting one or two claims initially. If, for some reason, MeCMS cannot process your adjustment, the claim will reject, suspend, or deny. If the adjustment is processed appropriately, continue to increase the volume of claims adjusted. If the claims reject or do not process correctly, please contact MaineCare Customer Service at 1 (800) 321-5557, Option 8 for assistance.

Hospitals: For hospitals that have outstanding balances as determined by CDR Associates and Public Consulting Group/Health Management Systems, a plan is being developed to process pending claim adjustments from Credit Balance Audits and the Medicare and Tri-Care Provider Billing Projects. For projects initiated prior to 2007, hospitals will be contacted by State staff before any adjustments relative to these projects are initiated. Specific questions should be directed to the Third Party Liability Division, at (207) 287-1801 or toll free at 1 (800) 472-3839.

Previously Submitted Adjustments: Adjustments that are in MeCMS today will **automatically** process upon the implementation of the adjustment functionality. This includes previous state-initiated adjustments and provider-initiated paper or electronic CMS/HCFA 1500 Claims, ADA Dental, and UB 92/04 claims entered directly into MeCMS that have not appeared on a remittance advice. Please review your on-going Remittance Advices to monitor the disposition of these adjusted claims. Please note, this DOES NOT include adjustments previously submitted directly to the Adjustment Unit on "Pink" and "Green" Adjustment Request Forms.

Interim Payment Recovery (IPR): The Interim Payment Recovery Team (IPRT) has developed a process to apply provider payments for adjusted claims toward a provider's interim payment balance. IPRT will be monitoring these additional payments to assess the need to recapture and apply them to interim balances that remain unjustified for providers to retain. This will benefit providers who have unjustified interim balances since it may reduce the need to send in checks or have automatic offsets implemented for recent claims.

Claims Processing Rules: Please note, any claim submitted for an adjustment today will be subject to rules that currently exist in MeCMS. If for any reason a particular edit was not correctly applied when the claim was initially processed and this edit has since been repaired, the edit will now be correctly applied, regardless of whether or not this was the provider's reason for submitting the adjustment. For example, prior to January 21, 2008, copayments were not deducted from claims processed. All claims subject to copayments submitted for adjustments now will have copayments deducted. Other examples include certain cost of care, certain modifiers and j-codes.

Cost Settlement: As with the void functionality, the implementation of the adjustment functionality may result in subsequent changes to the paid claims data relied upon in previously issued final audit cost settlements. Therefore, subject to the Principles of Reimbursement applicable to your facility, it may be necessary for the Office of Audit to reopen a previously issued final audit cost settlement report.

Claims Portal: Providers will be able to view adjusted claims in the Claims Portal by filtering for "All Claims." An adjusted claim will be displayed as a status "80."

INSTRUCTIONS FOR SUBMITTING ADJUSTMENTS

This document provides definition of terms and detailed instructions on how to use the adjustment functionality to maximize its benefits and features and minimize errors.

What **PROVIDERS CAN DO** with Adjustment Functionality. . .

Following the Implementation of Adjustment Functionality Providers CAN:

- Adjust an original paid claim document or paid claim line for which an adjustment was not previously submitted and approved

A general rule of thumb is that if claims are currently paying correctly, an Adjustment should result in a proper payment. If a claim is **NOT** paying correctly due to a known issue, then an **ADJUSTMENT SHOULD NOT BE SUBMITTED**, because the claim will encounter the same issue. Examples of these are limits and Edits Processing Failure (EPF).

Providers cannot adjust paid claim lines on documents with cost of care, spend downs, room and board, Private Non-Medical Institutions (PNMI), Third Party Liability (TPL), or Billing Provider Type = 31.

This means that a provider cannot submit a LINE-level adjustment if the original claim has the above attributes. Providers must contact their State Medical Support Specialist (Adjuster) if they need to submit a line-level adjustment for this situation; the Medical Support Specialist can perform the line-level adjustment.

Please Note: Providers **CAN** submit a HEADER level adjustment if the original claim has the above attributes. A similar requirement existed in the Voids initiative. The difference between the Adjustments and Voids requirement is that Adjustments now includes PNMI and TPL attributes.

- Adjust the Adjustment (replacement) claim line/document once the Adjustment line/document appears as paid on the Remittance Advice (RA).
- Adjust a document with a status of Adjudicated/RA generated (i.e., mix of Paid and Denied lines) at the **document level.** MeCMS will adjust the paid lines and ignore the denied lines during this process. Denied lines cannot be adjusted.
- Adjust paid lines from a claim document one line at a time. Any subsequent line from that same document can be adjusted once the Adjustment claim appears as paid on the RA.

> Each claim line must be submitted as a separate Adjustment document

What the **STATE CAN DO** with Adjustment Functionality. . .

Following Adjustment Functionality Implementation, the State CAN:

- Process Adjustments that were previously submitted in MeCMS
- Process Adjustments previously submitted on a pink or green form
- Process Adjustments previously submitted with a check so that funds are not offset, since payment has already been received

What Providers CANNOT do:

- . . .Adjust a claim line if there is a different line of the **SAME** original claim currently being adjusted (i.e. has not processed through to the RA)

> A line-level adjustment cannot be performed if a different line from the same document is currently being adjusted. This is not the case for voids.

- . . .Adjust LEGACY (pre-MeCMS) claim document or claim line (until further notice)
- . . .Adjust a DENIED claim document or claim line
- . . .Adjust a VOID claim document or claim line
- . . .Adjust a SUSPENDED claim
- . . .Adjust a claim held for Interim Payment Recovery (IPR)
- . . .Adjust a claim held in Edits Processing Failure
- . . .Adjust a claim held in Fund Allocation Failure
- . . . Resolve a current outstanding billing issue by submitting an Adjustment, e.g. limits issues that have not yet been resolved in MeCMS.
- . . .

> Special Note for MBCHP: Please be advised that adjustments for the Maine Breast and Cervical Health Program claims will be allowed only if submitted within 60 days of the **<u>original</u>** Claim Pay Order Date.
>
> Please call **1 (800) 350-5180** for further questions regarding the MBCHP.

SCHEDULE

1	Provider Training on Adjustment Functionality	03/31/08 - 04/18/08
2	Adjustment functionality code promoted to Production Environment	03/24/08
3	State and CNSI Validate adjustment functionality code	03/25/08 - 04/07/08
4	Three (3) "Pilot" Providers to submit "live" adjustment claims to MeCMS	03/26/08 - 04/07/08
5	Providers who received training (03/31 – 04/04) may submit adjusted claims	04/07/08
6	Providers who received training (04/07 – 04/11) may submit adjusted claims	04/14/08
7	All other providers may submit adjusted claims	04/21/08
8	State/system initiated adjustments begin (not necessarily in this order): • Claims that paid incorrect anesthesia rates between pay order dates 01/21/2005 to present • Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) providers paid incorrectly between 01/18/2005 and 05/31/2005 • Claims incorrectly paid at 100% between pay order dates 03/07/2005 and 03/28/2005 • Claims with procedure codes T033 which paid incorrect rate between pay order dates 10/4/05 and 12/22/05 • Radiology claims between 01/21/2005 and 03/06/2005 that paid incorrectly and radiology claim that paid at zero inappropriately • Assistant surgeons paid incorrectly at the surgeon rate • Claims with "PN" modifier that paid incorrectly at 100%	April 14, 2008

DEFINITIONS USED IN THIS DOCUMENT

Void: The complete reversal of a claim document or claim line
Adjustment: The revision of a claim document or claim line
Replacement: HIPAA term for adjustment.

USEFUL LINKS

Please Note: In the event that changes to these instructions or to the schedule above are required, urgent notifications will be provided via the MaineCare Services ListServ. In addition, you will receive up-to-date information on news that affects you! To ensure timely receipt of these notices, we invite you to sign up for this free service at **http://www.maine.gov/dhhs/bms/member/innerthird/listserv.shtml.**

Other Useful Links:
MaineCare Website: **http://www.maine.gov/bms/**
News You Can Use: **http://www.maine.gov/bms/member/innerthird/news_page.shtml**
MaineCare Billing Instructions: **http://www.maine.gov/bms/providerfiles/provider_billing_manuals.htm**
Electronic Media Claims (EMC) Instructions: **http://www.maine.gov/bms/provider/emc/emc_downloads.html.**
MaineCare Benefits Manual: **http://www.maine.gov/sos/cec/rules/10/ch101.htm**
Information on claims and interim payments: **https://portalxw.bisoex.state.me.us/oms/prv_pmts/ext_pfp.aspx?cf=op2**
Information on Claims Status: **https://portalx.bisoex.state.me.us/jav/DHHSClaimStatus_prod/requestStatus.jsp**
Prior Authorization (PA) Provider Information Sheets: **http://www.maine.gov/dhhs/bms/providerfiles/pacriteriasheets.htm**
Maine Breast and Cervical Health Program (MBCHP): **http://www.maine.gov/dhhs/bohdcfh/bcp/**

HOW TO SUBMIT ADJUSTMENTS

UB 92 Institutional Claims

1. Enter a "0" as the first digit in Form Locator (FL) 4
2. Enter a "7" as the last digit in FL 4, Type of Bill **AND**
3. Enter the Original TCN in FL 37 A

4.Type of Bill
0XX7

Example of a Header Adjustment – Entire Document Adjustment – Enter Document TCN
Submit the adjustment claim document as a replacement for the original claim.

37	
A	**002006115643030000**
B	
C	

Example of a Line Adjustment – Enter Line TCN
Submit the adjustment claim line as a replacement for the original claim.

37	
A	**002006115643030002**
B	
C	

UB 04 Institutional Claims

1. Enter a "0" as the first digit in Form Locator (FL) 4
2. Enter a "7" as the last digit in FL 4, Type of Bill **AND**
3. Enter the Original TCN in FL 64

4.Type of Bill
0XX7

Example of a Header Adjustment – Entire Document Adjustment – Enter Document TCN
Submit the adjustment claim document as a replacement for the original claim.

64 DOCUMENT CONTROL NUMBER
002006115643030000

Example of a Line Adjustment – Enter Line TCN
Submit the adjustment claim line as a replacement for the original claim.

64 DOCUMENT CONTROL NUMBER
002006115643030001

HCFA/CMS 1500 Professional Claims

1. Enter a "7" in Box 22, "Medicaid Resubmission" in the space for "Code" **AND**
2. Enter the Original TCN in Box 22 in the space for "Original Ref No"

Example of a Header Adjustment – Entire Document Adjustment – Enter Document TCN
Submit the adjustment claim document as a replacement for the original claim.

22. MEDICAID RESUBMISSION CODE	ORIGINAL REF NO
7	00200709006016000

Example of a Line Adjustment – Enter Line TCN
Submit the adjustment claim line as a replacement for the original claim.

22. MEDICAID RESUBMISSION CODE	ORIGINAL REF NO
7	00200709006016003

Dental Claims (ADA 1999 Version 2000 Form)

1. Enter a "7" **AND** the Original TCN in Box 61
   Example of a Header Adjustment – Entire Document Adjustment – Enter Document TCN
   Submit the adjustment claim document as a replacement for the original claim.

61. Remarks for unusual services
7 00200709006016000

   Example of a Line Adjustment – Enter Line TCN
   Submit the adjustment claim line as a replacement for the original claim.

61. Remarks for unusual services
7 00200709006016001

Electronic Institutional Claims

1. Enter a "7" in Record Type 10 in Field Number 2, Type of Batch. Field Number 2 consists of three segments, where the third segment is reserved for the Frequency Code, Form Locator 4. This is position 5.
2. Enter the Original TCN in Record Type 31 in Field Number 14, Form Locator 37. Field Number 14 begins at position 155 and is a length of 23 characters, more than the number of characters in a TCN. This field is left justified and the remaining characters left blank.
3. Record Type 31 only needs to exist if you are attempting to void or adjust a claim. Otherwise, this record should be left off the claim.
4. MaineCare has customized the use of these fields in Record 31, Third Party Payer information to meet our needs for voids and adjustments.
5. When adjusting entire documents, the electronic claim does not need to have the same number of lines as submitted in the original claim; however, it will need at least one line. When adjusting by line, enter only the line being adjusted.

Electronic Professional and Dental Claims

1. Submission Reason Code and Original TCN fields are located in Record G.
2. Enter a "7" in Position 41
3. Enter the Original TCN (either document or line) starting in Position 42
4. Record G only needs to exist if you are attempting to void or adjust a claim. Otherwise, this record should be left off the claim.
5. MaineCare has customized the use of the "Filler Fields" in the Professional and Dental claims to meet our needs for voids and adjustments.
6. Provider initiated adjustments at the line-level can only be done one line per claim. To adjust 3 lines from a claim, each adjustment submission would contain only one G Record as follows:

   B
   C
   E
   G (Original Line TCN)

   You would have to submit three separate claims to adjust the three lines from the same document. Note that if you are adjusting at the line-level, you only need to include that line you are adjusting.
   For example:

   First Submit:

   B Claim 1
   C Claim 1
   E Line 2
   G Line 2 (Original Line TCN)

   Wait for the claim to process to an RA

Then Submit:

B Claim 1
C Claim 1
E Line 3
G Line 3 (Original Line TCN)

Wait for the claim to process to an RA

Then Submit:

B Claim 1
C Claim 1
E Line 4
G Line 4 (Original Line TCN)

7. If you are adjusting at the document level, you do not need to include the same number of lines in the document as in the original document. You can think of the adjustment document as a replacement for the original document. For example, if the original document had two lines, but it should have had five lines, you may submit an adjustment for a 5-line document as follows:

B
C
E
E
E
E
E
G (Original Document TCN)

Remittance Advice (RA) and Electronic Remittance Advice (835) Changes:

RA Summary

- ☑ Receivable amounts will continue to be displayed
- ☑ Receivables will continue to be grouped by Provider and Adjustment Source.
- ☑ If a void and adjustment from the same Provider have adjudicated successfully during the same RA cycle, they will be grouped in the same receivable.

RA Details

- ☑ The credit claim will display before its corresponding adjustment claim.
- ☑ Denied Adjustment category will include adjustment claims that have adjudicated to Deny.

835 Indication of Adjustment Claim

- ☑ The CLP segment in Loop 2100 is used to identify adjustment claims. The Claims Status Code field, CLP02, will contain a value of "22" to represent a reversal of a prior claim.
- ☑ The Claim Frequency Type Code Field, CLP09, will contain the value of "7" for Institutional, Professional, and Dental claim types.

Please Note: Adjusting a claim results in new “credit” claims created in MeCMS, which will negate all claim attributes of the original claim. In addition, a new adjustment claim will be created as a replacement for the original claim. The first two digits of the new credit and adjustment TCN’s indicate the source of the adjusted claim as such:

00 = Provider initiated, paper
99 = Provider initiated, electronic (Electronic Media Claim-EMC)
22 = State initiated, system initiated or Correct Code Initiative – CCI - initiated

WHO TO CALL FOR CLAIMS ADJUSTMENTS

If you have any general questions on how to submit an adjustment, please contact **Billing and Information at 1 (800) 321-5557, Option 8.**

If you need to submit an adjustment listed above that needs Medical Support Specialists (formerly adjusters) intervention, please note that they are assigned by type of provider and first letter of provider name.

First letter applies to the **first line on the remittance advice.**

Provider Type	First Letter of Provider Name	Assigned Medical Support Specialist (See contact information below)
• Boarding Homes • Nursing Homes • Home Health Services • Hospitals	A – E	Linda Harrington
	F – L	Shavon Smith
	M – Z	Nancy Haskell
• Providers billing on CMS 1500 • Dentists • Transportation	A – E	Debbie Ladd
	F – N	Jaime Hall
	O – Z	Kathy Collins
• DMR Waiver	All	Shavon Smith
• Maine Breast and Cervical Health Program (MBCHP)	All	Shirley Chadbourne

If you are not able to determine whom you should contact from this table, please feel free to contact any Medical Support Specialist who will redirect your call to the appropriate person.

Contact Information	Telephone	E-mail
Linda Harrington	**287-1777**	Linda.Harrington@maine.gov
Shavon Smith	**287-6284**	Shavon.Smith@maine.gov
Nancy Haskell	**287-1779**	Nancy.Haskell@maine.gov
Debbie Ladd	**287-1780**	Debbie.Ladd@maine.gov
Jaime Hall	**287-1778**	Jaime.Hall@maine.gov
Kathy Collins	**287-3758**	Kathy.Collins@maine.gov
Shirley Chadbourne	**287-6285**	Shirley.Chadbourne@maine.gov

Maine Breast and Cervical Health Program (MBCHP) Questions: Please call **1 (800) 350-5180**

Frequently Asked Questions
Adjustment Functionality

	QUESTION	ANSWER
1	What claim attributes can be adjusted?	Any claim attribute other than the Billing Provider ID, Member ID and Room and Board Procedure Codes and/or Revenue Codes can be adjusted. The Billing Provider ID and Member ID must be identical to what is on the original claim. The only exception to this is if the original claim was filed with an Old Provider ID. In that case, the new provider ID must be used (in other words, the same provider must submit the adjusted claim using their new provider ID.)
2	Will providers who are billing for co-insurance and deductibles after Medicare on paper be able to adjust these claims?	Yes, Adjustment for these claims can be submitted however, adjustments (and Voids) related to Medicare co-insurance and deductibles must be submitted on paper. For **hospitals,** claims submitted on paper for co-insurance and deductibles after Medicare are **not** working properly at this time.
3	Should a hospital that has been cost-settled submit adjustments to cost-settled claims?	Hospitals should submit adjustments to claims in all circumstances where an adjustment is appropriate, regardless of whether or not an audit cost settlement has already been issued for that fiscal period. Depending on the results of these adjustments, there is a possibility that a previously issued final audit cost settlement report will be re-opened.
4	*What about non-hospital providers that have been cost-settled? Should claims be adjusted for dates of service provided in a fiscal period for which a final audit cost-settlement has already been issued?	It depends. If the payment/allowed amount (daily rate) was incorrect, but the number of units/days of service and dates of service are correct, then **NO,** the claim should not be adjusted. The payment for these days of service was adjusted to the final audited rate via the audit process. No further action is necessary. However, other types of adjustments such as, wrong cost of care was offset, incorrect number of units/days of service, incorrect dates of service, etc., then **YES,** the claim should be adjusted.
5	*Should non-hospital providers submit adjustments for dates of service provided in a fiscal period for which a final audit cost settlement has not been issued?	Yes, the claim can be adjusted. The payment for these days of service has not been adjusted to the final audited rate via the audit process.
6	How do I adjust a claim that was submitted with a modifier that has been closed by CMS?	Regardless of the modifier used at the time the original claim was submitted, please be sure to always use a new, valid modifier whenever you submit an adjustment to a claim that requires one.
7	Can I submit my own adjustments rather than waiting for the State to process the "pink" and "green" forms that have been submitted-to-date?	Providers can submit their own adjustments, rather than waiting. State staff will not be allowed to adjust that same claim a second time. **PLEASE NOTE:** "Pinks" that were submitted along with a **CHECK SHOULD NOT BE SUBMITTED AGAIN BY THE PROVIDER.** To do so will result in the adjustment being recouped from the Remittance Advice.
8	Should I submit any new adjustments using the "pink" or "green" Adjustment Request Forms?	Unless specifically instructed to do so by your Medical Support Specialist (Adjuster), you should not use "pink" or "green" forms. Voids and adjustments should be submitted using the appropriate claim form.
9	Can I adjust a claim that is being Held for Interim Payment Recovery?	No, the claim will either suspend or deny for "Former TCN Status Invalid."

*** Non-hospital cost-settled providers include Nursing Facilities, Residential Care Facilities, Private Non-Medical Institutions, Intermediate Care Facilities for the Mentally Retarded, and Day Habilitation providers.**